



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

EMERGENCY PHYSICIANS OF CENTRAL TX  
PO BOX 2283  
MANSFIELD TX 76063

#### **Respondent Name**

Texas Mutual Insurance Co

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-0898-01

#### **MFDR Date Received**

November 17, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "... pt presented to the Er after hours."

**Amount in Dispute:** \$96.70

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Although the requestor certified in the medical record the admission was a medical emergency the same medical record does not rise to the level required of an emergency as defined by DWC Rule 133.2..."

**Response Submitted by:** Texas Mutual Insurance Co

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2011	Outpatient Hospital Services	\$96.70	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
  - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
  - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

## Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. Is the requestor entitled to reimbursement?

## Findings

1. The insurance carrier denied disputed services with reason code, 899 – “DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2”. 28 Texas Administrative Code §133.2(4)(A) states that, “a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient’s health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
  - a. Nurse Documentation (page 1 of 2) shows “Pain: Patient rates pain as 4 on a one-to-ten scale... and ...Onset of pain was gradual, more than a week ago.”
  - b. Physician Documentation (page 1 of 3) “Patient states symptoms are of moderate intensity.”

The Division concludes the denial code 899 is supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Requestor did not support definition of medical emergency.

## Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
December , 2013  
Date

## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**